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No. 80-422

In the Supreme Court of the United States

October Term, 1980

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION and THE HOSPITAL ASSOCIATION OF PENNSYLVANIA,
Appellants

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE and HELEN B. O'BANNON,
Appellees

On Appeal From the Supreme Court of Pennsylvania

MOTION OF APPELLEES TO DISMISS

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COUNTER-STATEMENT OF THE QUESTION PRESENTED

Whether this case presents a substantial federal question for review by this court.

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STATUTES INVOLVED

42 U.S.C. §1396a (a) (13) (B) (C):

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1396d (a) of this title, and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1396d (a) of this title or

(ii) (I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

42 U.S.C. §1396a (a) (17):

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect

to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter, as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to State eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to

States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

42 U.S.C. §1396a(a)(23):

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) had entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic;

42 U.S.C. §1396a(a)(30):

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and ser-

vices available under the plan (including but not limited to utilization review plans as provided for in section 13-96b (i) (4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

42 U.S.C. §1396a (b):

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) . . .

Pa. Stat. Ann. title 62 §§201 (1) and (2) (Purdon):

201. State participation in cooperative federal programs.

The department shall have the power:

(1) With the approval of the Governor, to act as the sole agency of the State when applying for, receiving and using Federal funds for the financing in whole or in part of programs in fields in which the department has responsibility.

(2) With the approval of the Governor, to develop and submit State plans or other proposals to the Federal government, to promulgate regulations, establish and enforce standards and to take such other measures as may be necessary to render the Commonwealth eligible for available Federal funds or other assistance.

Pa. Stat. Ann. title 62 §403 (b) (Purdon):

(b) The department shall establish rules, regulations and standards, consistent with the law, as to eligi-

bility for assistance and as to its nature and extent. The secretary or his designee in writing is the only person authorized to adopt regulations, orders, or standards of general application to implement, interpret, or make specific the law administered by the department. The secretary shall issue interim regulations whenever changes in Federal laws and regulations supersede existing statutes. In adopting regulations, orders, or standards of general application, the secretary shall strive for clarity of language which may be readily understood by those administering aid and by those who apply for or receive aid.

Pa. Stat. Ann. title 62 §443.1 (1) (Purdon):

443.1 Medical assistance payments for institutional care.

The following medical assistance payments shall be made in behalf of eligible persons whose institutional care is prescribed by physicians:

(1) The reasonable cost of inpatient hospital care, as specified by regulations of the department adopted under Title XIX of the Federal Social Security Act and certified to the department by the Auditor General for a bed patient on a continuous twenty-four hour a day basis in a multi bed accommodation of a hospital, exclusive of a hospital or distinct part of a hospital wherein twenty-five percent of patients remain six months or more. To be eligible for such payments a hospital must be qualified to participate under Title XIX of the Federal Social Security Act and have entered into a written agreement with the department regarding matters designated by the secretary as necessary to efficient admin-

istration, such as hospital utilization, maintenance of proper cost accounting records and access to patients' records. Such efficient administration shall require the department to permit participating hospitals to utilize the same fiscal intermediary for this Title XIX program as such hospitals use for the Title XVIII program;

REGULATIONS INVOLVED

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42 C.F.R. §440.40 (a) (1):

Skilled nursing facility services for individuals age 21 or older (other than services in an institution for tuberculosis or mental diseases). EPSDT, and family planning services and supplies.

(a) Skilled nursing facility services.

(1) "Skilled nursing facility services for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases," means services that are

(i) Needed on a daily basis and required to be provided on an inpatient basis under §§405.127, 405.128, and 405.128a of this chapter;

(ii) Provided by a facility or distinct part of a facility that is certified to meet the requirements for participation under subpart C or part 442 of this subchapter, as evidenced by a valid agreement between the medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan; and

(iii) Ordered by and under the direction of a physician.

42 C.F.R. §440.150 (d) :

Intermediate care facility services, other than in institutions for tuberculosis or mental diseases.

(d) "Intermediate care facility services" may include services provided in a distinct part of a facility other than an intermediate care facility if the distinct part

(1) Meets all requirements for an intermediate care facility;

(2) Is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;

(3) Consists of all beds and related facilities in the unit;

(4) Houses all recipients for whom payment is being made for intermediate care facility services, except as provided in paragraph (e) of this section;

(5) Is clearly identified; and

(6) Is approved in writing by the survey agency.

COUNTER-STATEMENT OF THE CASE

Appellants, Temple University—of the Commonwealth System of Higher Education (Temple University) and The Hospital Association of Pennsylvania, have appealed the judgment of The Supreme Court of Pennsylvania entered on June 19, 1980, and reported at Pa. , 415 A.2d 413 (1980). The Supreme Court there affirmed the decision of the Commonwealth Court, reported at 47 Pa. Commonwealth Ct. 22, 407 A.2d 92 (1979), which held that Appellees' manner of reimbursement to hospitals for care provided to patients who no longer require acute inpatient care but rather skilled nursing or intermediate care but who cannot be transferred immediately to another facility, is reasonable and consistent with applicable Federal and State law.

Appellants seek to invoke this Court's jurisdiction pursuant to 28 U.S.C. §1257(2) by asserting that their appeal involves a substantial federal question. To this end Appellants argue that Appellees reimbursement policy is inconsistent with federal law and is violative of the constitutional guarantee of equal protection.

Appellees, Commonwealth of Pennsylvania, Department of Public Welfare, and Helen B. O'Bannon, Secretary, Department of Public Welfare, here move to dismiss the instant appeal pursuant to Supreme Court Rule 16(b), because it does not present a substantial federal question.

The issue presented to the State courts was the validity under state and federal law of Pennsylvania Medical Assistance Manual Section 9421.74(q). Appellants' argu-

ment before the State courts has been that the regulation is beyond the Appellees' authority to adopt; violates the constitutional guarantee of equal protection of the laws; and is inconsistent with applicable federal law. Appellants have maintained that notwithstanding a medical determination that a patient no longer requires acute inpatient hospital care but rather requires skilled nursing or intermediate care, a hospital is entitled to receive reimbursement at its acute care rate for so long as the patient remains in the hospital.

Appellees have implemented a reimbursement mechanism, which mechanism is set forth in its approved State Plan, whereby a hospital which has a unit certified as a skilled nursing or intermediate care nursing unit can be reimbursed, albeit at a rate that is lower than the hospital's acute care rate, for the care provided to Medical Assistance eligible recipients who no longer require acute inpatient hospital care.[1] While challenging the Appellees' reimbursement system, Appellants, in their original complaint filed with the Commonwealth Court below, admitted that the inability of a hospital to transfer a patient to a lesser level care institution occurred from but "time from

[1] States are not required to institute a Medicaid Program, but if they choose to do so, they must submit to the Department of Health and Human Services (HHS) a satisfactory "State Plan" which fulfills all the requirements of Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.* See 42 U.S.C. §1396a. The Secretary of HHS must approve a Plan which meets all requirements of the statute and implementing regulations. 42 U.S.C. §1396a(b). The State thereupon becomes entitled to grants of federal funds in reimbursement for a portion of the expenditures which it makes in providing specific types of Medical Assistance to eligible individuals under the Plan.

time". Appellants have argued that they are entitled to reimbursement at the acute care rate and cannot be required to establish certified units as a prerequisite to obtaining reimbursement.[2]

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[2] At the time the case was before the state courts, the acute care rate at Temple University Hospital was $265.00 per day. The per diem rate for hospital based units was $42.00 per day for operating costs, depreciation costs being reimbursed separately.

Argument

THIS CASE DOES NOT PRESENT A SUBSTANTIAL FEDERAL QUESTION

A. Operation of the Medicaid Program

Title XIX (Medicaid) provides for the establishment of a cooperative Federal-State Program to provide payments for medical services rendered to certain needy individuals whose income and resources are insufficient to meet the costs of these services. Participation in the Medicaid Program by a State is voluntary, but in order to qualify for federal funds, the State's Program must meet certain federal requirements. 42 U.S.C. §1396a. The State must have an approved State Plan which meets all the requirements of the statute and implementing regulations. 42 U.S.C. §1396a(b). The State thereupon becomes entitled to grants of federal funds and reimbursement for a portion of its expenditures in providing specific types of medical assistance to eligible individuals under the plan in accordance with federal requirements. 42 U.S.C. §1396b. Pennsylvania participates in the Medicaid Program under an approved State Plan.

It is the States which actually administer the individual State plans, and, within the scope of Title XIX, there is much room for the States to design their own programs. The introductory section of Title XIX sets forth the general statement of purpose of the Act and clearly expresses the broad flexibility Congress intended to give

the States in developing and administering Medical Assistance Programs.

> "§1396. Authorization of appropriations.
>
> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services, ..."

Furthermore, in *Beal v. Doe,* 432 U.S. 438, 441 (1977), this Court, in deciding whether a State Plan which denied funds for abortions unless they were certified by a physician as "medically necessary" was violative of Title XIX, held:

> Although Title XIX does not require States to provide funding for all medical treatment falling within the five general categories it does require that State Medicaid plan establish 'reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX].' 42 U.S.C. §1396a (a) (17) (1970 ed., Supp. V).

This Court emphasized that the Act confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be reasonable and consistent with the objectives of Title XIX. *Beal v. Doe,* 432 U.S. at 444. See also, *Preterm, Inc. v. Dukakis,* 591 F.2d 121 (1st Cir. 1979), *cert. denied, Baird v. Pratt,* U.S. , 99 S.Ct. 2181 (1979). Appellees submit that §9421.74 (q) neither conflicts with Federal law nor denies equal protection.

B. Pennsylvania Medical Assistance Regulation 9421.74 (q) Does Not Conflict With Title XIX of the Social Security Act

The administrative regulation at issue in this case is Pennsylvania Medical Assistance Regulation 9421.74 (q). Section 9421.74 (q) was adopted by the Pennsylvania Department of Public Welfare (DPW) pursuant to its delegated legislative rulemaking authority as set forth at Sections 201 (1) and (2), 403 (b) and 443.1 (1) of the Public Welfare Code (Pa. Stat. Ann. title 62, §§201 (1) and (2), 403 (b), 443.1 (1) (Purdon)). Section 9421.-74 (q) is part of the regulatory scheme that implements Pennsylvania's federally approved State Plan for Medical Assistance. The State Plan establishes different classes of nursing care facilities.[3] Under Section 9421.74 (q) skilled and intermediate nursing care services provided by a hospital that has an effective nursing care provider agreement[4] are reimbursed for as long as the services are medically necessary.

Appellees through the adoption of §9421.74 (q), have implemented a medical assistance program delivery and reimbursement scheme that is consistent with federal law governing the types of inpatient hospital services which may be provided, i.e., acute care and skilled or interme-

[3] These classes are: general (privately owned) nursing facilities; public (county owned) nursing facilities; intermediate care facilities for the mentally retarded; psychiatric transitional facilities for the mentally ill; and hospital-based facilities.

[4] Federal Regulations provide for the creation of hospital based distinct part nursing care units. 42 C.F.R. §§440.40(a)(1) and 440.150(d).

diate nursing care in a distinct part of a hospital. See 42 C.F.R. §§440.10, 440.40 and 440.150. Appellees have followed the federal mandate that they provide for methods and procedures intended to safeguard against payments for services which are in excess of reasonable charges consistent with efficiency, economy, and quality of care, and that services be provided by a facility certified to provide the service, by distinguishing between the three different levels of reimbursement to hospitals for the care actually needed by individual patients. See 42 U.S.C. §1396a(a)(17) and (30).

As evidenced by reference to applicable federal regulations, these distinctions are consistent with federal law and have been implemented pursuant to an approved State Plan. The fact that the Plan has obtained such approval is significant in that great deference is to be given to interpretations of regulations by the agency charged with the administration of the statute. See, *New York State Department of Social Security v. Dublino,* 413 U.S. 405, 421 (1973); *Red Lion Broadcasting v. FCC,* 395 U.S. 367 (1969). Approval by HHS of the current State Plan, providing as it does, for distinct part hospital based nursing care facilities, certifies that the Plan, from the perspective of HHS, is consistent with applicable law.

Appellants contend, however, that this system violates the provisions of 42 C.F.R. §440.230(b) and (c) in that Appellees arbitrarily have denied or reduced services to otherwise eligible recipients. Indeed, Appellants allege that the importance of the issue presented here for review is the need for the Court to render a definitive statement of the legal standard which all States must follow in determining which services they are required to provide under

the Medicaid Program.[5] Even assuming that a service reduction was involved here, no such statement by this Court is necessary. Those courts which have been presented with disputes concerning a state's authority to reduce services under a public service program, such as Medicaid, have recognized the state's right to establish priorities within the constraints of State and federal appropriations so long as the services provided are sufficient to reasonably achieve the purpose of the program. *Beal v. Doe, supra; Quern v. Mandley,* 436 U.S. 725 (1978); *Curtis v. Taylor,* Nos. 78-2203, 79-2244 (5th Cir. Sept. 11, 1980); *Zbraz v. Quern,* 596 F.2d 196 (7th Cir. 1979); *Preterm Inc. v. Dukakis,* 591 F.2d 121 (1st Cir. 1979), *cert. denied, Baird v. Pratt,* U.S. , 99 S.Ct. 2181 (1979); *Doe v. Colautti,* 592 F.2d 704 (3d Cr. 1979). As there have been no conflicting decisions in this area of the law, Appellants' description of the issue as being of "central importance" is a gross misstatement.

Appellants' misperception of the case law in this area aside, the provisions of 42 C.F.R. §440.230(b) and (c)

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[5] Appellants contend that the decision in *White v. Beal,* 555 F.2d 1146 (3d Cir. 1977) conflicts with that of the Pennsylvania Supreme Court in this case, thus raising an independent reason for the Court to assume jurisdiction. Appellees suggest that *White v. Beal* is inapposite to the issue presented here. At one time, eyeglasses were covered under the Pennsylvania Medical Assistance Program only to correct vision impaired by eye disease. Persons with refractive error were not eligible for eyeglasses. This distinction was held to be contrary to the express provisions of 42 C.F.R. 440.230(c)(1). No such disparity exists under the state regulation at issue below. *All* Medical Assistance recipients are eligible for acute hospital care, for skilled nursing care and for intermediate care from certified providers of such services.

simply are not relevant to this case. The manner of reimbursement utilized by the Appellees permits them to assure the delivery of acute inpatient hospital care, skilled nursing care, and intermediate care in their entirety to the Medicaid population as a whole while simultaneously working in a responsible manner to maintain the fiscal solvency of the Pennsylvania Medical Assistance Program. This manner of reimbursement is consistent with the letter of Title XIX as well as with the case law that has developed concerning implementation of that statute. 42 U.S.C. §§1396, 1396a(a)(17), 1396a(a)(30); *Beal v. Doe, supra; Preterm Inc. v. Dukakis, supra; Doe v. Colautti, supra, Medical Society of New York v. Toia,* 560 F.2d 535 (2d Cir. 1977); *Virginia Hospital Association v. Kenley,* 427 F. Supp. 781 (E.D. Va. 1977); *District of Columbia Podiatry Society, et al. v. The District of Columbia,* 407 F. Supp. 1259 (1975); *Monmouth Medical Center v. State of New Jersey,* 80 N.J. 299, 403 A.2d 487 (1979). See also the legislative history of the 1972 amendments to Title XIX which is replete with expressions of congressional concern for these goals. (1972 U.S. Code Cong. & Ad. News 4982, 4994, 5001-5007, 5008, 5060, 5075, 5086-5087).

Appellants, of course, have conceded there is no continuing need for acute inpatient hospital care for the patients for whom reimbursement has been disallowed under §9421.74(q). It necessarily follows from this admission that the coverage provided for acute care is sufficient to reasonably achieve its purpose.

With respect to patients who require skilled or intermediate nursing care, including those patients who no longer require acute inpatient care, the Department reim-

burses the delivery of those services provided by a facility that has an effective nursing care provider agreement with the Department *for as long as the services are medically necessary.* These nursing care services may be provided by a free-standing nursing care facility that is certified and that is operated by a local county government, a private profit or non-profit corporation, or by a hospital with a certified distinct part nursing care unit.

The Department submits that insofar as the majority of Medicaid eligible patients are concerned, this system provides adequate coverage to meet their needs. Indeed, Appellants themselves admit in Paragraph 12 of their Complaint in Equity, that any difficulty they experience in placing former acute care patients into non-acute care beds occurs only from "time to time".

Appellants, unable to establish any inconsistencies between federal statute or regulation and the state regulation at issue, also attempt to convince this Court that the New Jersey Supreme Court has taken a position inconsistent with that of Pennsylvania on the same issue. This argument too is unpersuasive. In *Monmouth Medical Center v. State of New Jersey, supra,* the New Jersey Supreme Court was presented with a state regulation that denied hospitals reimbursement for services rendered while patients were awaiting transfer to lesser level of care facilities. Unlike the present case, however, the New Jersey regulations made *no provision* whatsoever for a hospital to obtain reimbursement for the care it provided to patients pending their transfer to alternative health care facilities.

Although recognizing and sympathetic to the state's legitimate interest in allocating limited resources in the

most efficient manner possible and in discouraging over-utilization of hospital facilities, the court held that the regulation unreasonably denied reimbursement to those hospitals which, due to conditions beyond their control, could not transfer their patients to a skilled or an intermediate nursing care facility.

Although the court invalidated the regulation, it did so on the basis that the regulation failed to provide *any* mechanism whereby the hospital could be reasonably reimbursed for the nursing care services rendered. The Court then defined what it considered to be the equitable solution to the matter:

> [W]e note that the obvious equitable solution would be to reimburse hospitals in such circumstances at a rate commensurate with that of the lesser care facility which could provide the needed services. *Monmouth Medical Center v. State of New Jersey,* 403 A.2d at 493.

The only difference between the solution advocated by the New Jersey Supreme Court and Regulation 9421.-74(q) is that if Appellees are to assure federal financial participation (approximately 55% of the service cost) for services provided to a non-acute care patient in a hospital, the hospital must have a certified nursing unit. See 42 C.F.R. §§440.40(a)(1); 440.150(d). Pursuant to the mandate in Section 201(1) of the Pennsylvania Public Welfare Code, Pa. Stat. Ann. title 62, §201(1) (Purdon), that the Department do all things necessary to obtain federal funding, and as a matter of sound administrative judgment, the Department requires that a hospital establish such a unit if it is to qualify for Medicaid reimbursement.

In sum, Appellants have failed to cite to any federal law or to any federal or state court decision that even remotely supports their contention. To the contrary, there are no statutes to be interpreted, no conflicting decisions among the circuits to be resolved and no novel or important principles of law presented by this case which merit review by this Court.

C. Section 9421.74(q) Does Not Deny to Medical Assistance Patients Equal Protection of the Law as Guaranteed by the Fourteenth Amendment to the United States Constitution

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Appellants also assert that the Pennsylvania Medical Assistance Program has created, through §9421.74(q) a category of persons who somehow are distinguishable from other persons who are eligible for Medical Assistance. In particular, the "class" would consist of hospital patients who no longer require acute inpatient care, but who are in need of skilled or intermediate nursing services and for whom no lesser level of health care facility is available.

Pennsylvania submits that a separate category of Medical Assistance patients has not been established by this regulation. More correctly, the regulation applies uniformly to all persons who are eligible for Medical Assistance benefits. In that respect the regulation is one of "general applicability" and satisfies the equal protection principle without further inquiry. "General rules that apply evenhandedly to all persons within the jurisdiction unquestionably comply with this principle. Only when

a governmental unit adopts a rule that has a special impact on less than all the persons subject to its jurisdiction does the question whether this principle is violated arise." *New York City Transit Authority v. Beazer,* 440 U.S. 568, 587-588 (1979). As applied, §9421.74(q) neither diminishes nor abolishes an eligible recipient's entitlement either to acute inpatient services or to skilled care or intermediate nursing services from a certified provider.

In this case, a benefit has not been denied to some persons who are otherwise similarly situated, while granted to others. What Appellants fail to recognize is that §9421.74(q) does not diminish a recipient's entitlement to necessary care. Under Title XIX, eligible recipients are only entitled to the receipt of *covered* services from certified providers of those services. 42 U.S.C. §§1396, 1396a(a)(23). Thus if an otherwise eligible Medical Assistance recipient receives medical care from a provider that does not participate in the Medical Assistance program, the care rendered to that person will not be reimbursed by the Medical Assistance program. Indeed, there may be any number of otherwise Medical Assistance eligible persons whose care will not be reimbursable until such time as they are treated by a certified provider. Payment for medical care of any kind under the Medical Assistance program is not based wholly on the need of the client, but depends as well on the type of service provided and the eligibility of the provider.

The Social Security Act provides that the purpose of the Medicaid Program is to enable each State "as far as practicable under the conditions in such State" to furnish medical assistance to certain needy individuals. 42 U.S.C. §1396a. The general criteria for eligibility under the pro-

gram are that the recipient be eligible for coverage, that the service be provided under the program, and that the provider be certified to provide the service. These general criteria apply equally to all recipients with respect to all services.

Here the patients awaiting transfer to another facility are not being denied a service that otherwise eligible persons in need of nursing care are being provided. These patients are not being denied service from a provider who is simultaneously providing the same service to other medical assistance recipients. Likewise, these patients are not being denied a service available to persons with the same needs due to a discriminatory application of eligibility criteria. Regardless of the medical necessity for the service, a Medicaid recipient is not entitled to receipt of a service under the Medical Assistance Program when the service is provided by a non-certified provider.

To the extent that patients awaiting transfer to another facility are denied coverage for non-acute care services provided, they are treated no differently than any other medical assistance recipient. Conversely, to the extent that Medicaid eligible persons receive care from a certified provider of skilled nursing or intermediate care services, those persons, and the acute care patients awaiting transfer, are not similarly situated. In neither case is there a violation of the equal protection clause.

CONCLUSION

Wherefore, Appellees respectfully submit that the question upon which this appeal depends is so unsubstantial as not to need further argument, and Appellees respectfully move the Court to dismiss this appeal.

Respectfully submitted,

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JEFFREY GONICK
Assistant Attorney General
Department of Public Welfare

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980
No.

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION,

Appellant

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE and HELEN O'BANNON

Appellees

CERTIFICATE OF SERVICE

Jonathan Vipond, III, Esquire, hereby certifies that he is a member of the bar of the Supreme Court of the United States and counsel for the Commonwealth of Pennsylvania, Department of Public Welfare and Helen O'Bannon, Appellees in the above matter; that on November 3, 1980, three copies of Appellees' Motion to Dismiss were mailed, first class, pre-postage paid to Matthew M. Strickler, Esquire, 30 South 17th Street, Philadelphia, PA 19103, counsel for Appellant, Temple University, and to Roland Morris, Esquire, 1600 Land Title Building, Philadelphia, PA 19110, counsel for Appellant, The Hospital Association of Pennsylvania.

JONATHAN VIPOND, III
Counsel for Appellees